UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
NORTHERN DIVISION

THE UNITED STATES OF AMERICA — PLAINTIFF

VS. — CIVIL NO. 3:16CV00622CWR-FKB

THE STATE OF MISSISSIPPI — DEFENDANTS

TRIAL TRANSCRIPT
VOLUME 11

BEFORE THE HONORABLE CARLTON W. REEVES
UNITED STATES DISTRICT JUDGE
AFTERNOON SESSION
JUNE 12, 2019
JACKSON, MISSISSIPPI

REPORTED BY: CHERIE GALLASPY BOND
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*** DAILY TRANSCRIPT ***

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FOR THE PLAINTIFF: MS. REGAN RUSH
MS. HALEY VAN EREM
MR. JORGE MARTIN CASTILLO
MR. PATRICK HOLKINS

FOR THE DEFENDANT: MR. JAMES W. SHELSON
MR. REUBEN V. ANDERSON
MS. MARY JO WOODS

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THE COURT: All right. Are we ready for the cross-examination of Dr. Baldwin?

MR. SHELSON: Yes, Your Honor.

THE COURT: Dr. Baldwin, you may return to the stand.

MR. SHELSON: May I proceed, Your Honor?

THE COURT: You may.

CROSS-EXAMINATION

BY MR. SHELSON:

Q Good afternoon, Doctor. Did you testify this morning that some people that you interviewed in Mississippi thought they were committed to a state hospital against their will?

A I don't believe I testified that they said it was against their will. It was more that I said people that I interviewed wanted to leave.

Q Aren't, be that as it may, all civil commitments to a hospital involuntary material?

A I believe they are.

Q So in that sense, all civil commitments to any state hospital are against the individual's will. Is that correct?

A It would mean, yes, they don't have a choice. Some may be more against it than others.

Q When did you last have an active inpatient case load?

A So patients who are in a hospital at the time?

Q Yes.

A That's a very long time ago.

Q Approximately how long ago?
A That was at the beginning of my career. So that would be in 1972.
Q When did you last have an active outpatient case load?
A I had that in -- I had an outpatient case load in between 2010 and 2013. I also had one while I was at the VA from 2009 to 2015.
Q So your last active outpatient case load was sometime in 2015?
A Yes, sir.
Q Okay. You talked a good bit this morning about the Massachusetts mental health system. Do you recall that?
A I do.
Q Did your career start out in New York?
A It did.
Q And then at some point, did you move to Massachusetts?
A I did.
Q And when did that occur?
A When did I move to Massachusetts?
Q Yes, ma'am.
A 1976.
Q And has your -- have you been in Massachusetts ever since?
A Yes, I have.
Q Does every adult with SMI in Massachusetts who needs mobile crisis get that service?

A I don't know. I don't know that information. As you say every adult, so I don't know. Do you mean now?
Q Yes.
A I don't know.
Q Does every adult with SMI in Massachusetts who needs case management get that service now?
A I don't know.
Q Do you know what percentage of the adults with SMI in Massachusetts who need case management currently get that service?
A No, I don't.
Q Do you know what percentage of adults with SMI in Massachusetts get the standard of discharge planning that you testified about this morning?
A Do you mean presently or --
Q Presently.
A No, I do not know.

MS. VAN EREM: Objection, Your Honor. Dr. Baldwin has testified that her employment with the State of Massachusetts ended in 2009, and she's repeatedly told Mr. Shelson that she does not know the answer to the current questions regarding the state of Massachusetts.

THE COURT: Objection overruled.

BY MR. SHELSON:
Q That's a nice segue of where I was going next, Dr. Baldwin.

So let's talk about what period of time that you were able to testify about the Massachusetts mental health system. You said you started working in Massachusetts in 1976?

A Nineteen -- I moved there in '76, and I went to school, but I didn't start with the Department of Mental Health work that I testified about this morning until 1978.

Q Is 1978 when Massachusetts started introducing community-based services?

A I don't know if it was exactly that year, but it was about that same that it was starting to take hold, and there were, as I said this morning, in variance regions, task groups or groups of staff that were tasked with bringing people out of the state hospital.

Q As we sit here today, is Massachusetts still working on expanding its community-based services to meet the needs of adults with SMI in that state?

A I don't know.

Q What period of time -- is there any period of time you know the answer to that question up to?

A Can you repeat the question?

Q Did you testify this morning that you're familiar with the Massachusetts mental health system up to 2009?

A What I was familiar with up until 2009 is the work I was doing in the agency, the community-based agency that I worked in. So it was primarily focused on the northeast of

Massachusetts.

Q In 2009, were community-based services still being expanded in northeast Massachusetts?

A Always. It was a continuous process of fine-tuning services, building new services, improving on old ones.

Q To your knowledge, are there any unmet mental health needs for adults with SMI in Massachusetts now?

A I don't know.

Q Were there any unmet needs for adults with SMI in northeast Massachusetts in 2009?

A Yes, I would say so.

Q You testified this morning that community-based services reduced the risk of hospitalization?

A Did I testify this morning that community-based services can reduce risk of hospitalization?

Q Yes.

A Yes, I did.

Q Do you remember this slide from this morning, this PDX-18?

A Yes, I do.

Q This is a summary of your findings in Mississippi. Is that correct?

A Yes, it is.

Q And you found, based on the individuals you reviewed in Mississippi, that 100 percent of them would have avoided or spent less time in a hospital if they had received sufficient

community-based services?
A Would have avoided or spent less time in a state hospital if they had received the services, yes.
Q This is Exhibit D-320, which was previously admitted into evidence.
THE COURT: Okay.
BY MR. SHELSON:
Q Did you find that 19 of the 30 individuals you reviewed in Mississippi need PACT services?
A I would like to refer to my --
Q Sure.
A -- report, if that's all right.
Q Sure.
A The number of PACT services, that was related to the tally that you and I did at the deposition. I don't believe I have it counted in my report.
Q I'll represent to you this is the number we agreed on, and it's been stipulated to by the parties.
A Okay. All right.
Q So 19 of 30, again, I'll represent to you that that's 63 percent of the individuals you reviewed in Mississippi you recommended PACT services for?
A Yes.
Q In connection with the review that the DOJ experts did in Mississippi of the 154 individuals, did DOJ's expert, Robert

Drake, circulate a paper on how effective community-based services are at reducing hospitalization?

A He did. It was before we got started. It was a review of the literature.

Q This is Exhibit D-235. Do you recognize this as the paper that we just discussed that circulated by Dr. Drake?

A I do.

Q All right. And you see here that based on Dr. Drake's review of the literature, he found that assertive community treatment was 41 percent effective in reducing hospitalizations. Is that correct?

A Yes.

Q And to avoid hospitalization altogether, 100 percent of the time, obviously, if you -- strike that. If you are going to avoid hospitalization 100 percent of the time if you receive sufficient community-based services, those services are going to have to be 100-percent effective at reducing hospitalization. Is that correct?

A So that's a hypothetical question?

Q Yes.

A If you want to eliminate hospitalization altogether, the approach that you are using has to be 100-percent effective.

Q Yes.

A In a hypothetical situation, I would agree. But there's a list of services, and so sometimes it involves a combination.

And I think to have 100 percent of anything is very difficult, if not impossible.

Q Did Dr. Drake's paper find that there's a lack of data on the combined effectiveness of community-based services on reducing hospitalizations?

A Yes, he did. The exact recipe is still -- the studies are not conclusive.

Q Another service you mentioned this morning about being effective at reducing hospitalization was case management. Is that correct?

A That's correct.

Q Did Dr. Drake's paper find that there's a lack of data on the effectiveness of case management at reducing hospitalizations?

A Yes.

Q This is page 2 of Exhibit D-235. If I may direct your attention to the highlighted part, highlight sentence. It reads -- I'm sorry. This is talking about case management. And anyway, it goes on to say, "Intervention also reduces length of hospitalizations, no RR." Do you know what "no RR" means?

A I don't.

Q Okay. One more thing before I leave Dr. Drake's paper. What Dr. Drake, in his paper, calls hospital diversion services, are those -- and they're listed here in number one --

are those crisis services?
A Yes.
Q And what did -- how effective, based on Dr. Drake's review of the literature, are diversion services at reducing hospitalizations?
A 50 percent.
Q For the individuals that you interviewed in Mississippi, did your interviews last approximately one hour each?
A Yes.
Q I want to talk about person 90 briefly. Was person 90 one of the individuals you discussed this morning?
A Yes, she is.
Q And is person 90 the individual who you testified was evicted from her apartment for not paying rent?
A Yes.
Q Okay. And I believe your testimony was that what could have been done to prevent her hospitalization while that was going is for, I think you said, a case manager to talk to person 90, her daughter and her landlord?
A To work with her proactively to have an ongoing relationship, an outreach proactive relationship, yes.
Q Right. And that outreach, did you testify that that included speaking with person 90, as well as her daughter and her landlord?
A Yes.

Q And you agree with me that whatever case manager is doing, that takes some amount of time?
A Absolutely.
Q And how much of the case manager time that's going to take on a case-by-case basis will depend on how far the case manager has to travel to meet with and speak with those individuals?
A That is one factor, yes.
Q And there are a host of other factors. Correct?
A Yes.
Q And do you agree that the number of individuals case managers can deal with at any given time is a finite number?
A Yes.
Q Sticking with person 90, I want to go back to PDX18 in the left-most column. "Would have avoided or spent less time in the hospital." You agree those are two different things?
A I agree.
Q Okay. Did you arrive at a conclusion in your report regarding whether person 90 would have avoided hospitalization altogether or whether she would have went to the state hospital but spent less time there?
A I don't believe I separated it out in my report.
Q Did you separate it out in your report for any of the individuals you reviewed in your report?
A No, because it was mixed. Some might have spent less time, some might have avoided, or it might have been earlier

hospitalizations that they would have avoided or spent -- there was too many moving parts. And because it was a two-pronged question, I answered it together.

Q But correct me if I'm wrong, but I understood your testimony this morning to be that you believed person 90 would have spent less time in the state hospital?

A Yes. That's true for her.

Q Is it quantified or otherwise stated in your report how much less time person 90 would have spent in a state hospital?

A No, not quantified.

Q Is it quantified for any of the individuals in your report?

A No.

Q Doctor, what is -- well, we've heard this -- I hate to belabor the record, but I want to make sure we're on the same page. What is your understanding of what scatter site housing is?

A I don't know what it is.

Q What is your understanding of permanent supported housing?

A Do you mean in general?

Q Yes, ma'am.

A In general, to me, meaning not specific to a state, permanent supported housing is housing that an individual has that they are not -- it's not time limited, or they are not at risk of being moved out of it, that they would receive support with that housing. They might receive a rent subsidy.

Q If we could turn to your report, please, which is PX-403 and page 27, please. This is person 91.
A Yes.
Q Have you had -- have you had a chance to look at it sufficiently to know who I'm talking about?
A I know who you're talking about.
Q Okay. Thank you. Did you recommend for person 91 three to four-bed house staffed with people who could work with double amputees?
A I believe I did, but I can find it in my report to be sure. But that is what I believe I did, yes.
Q Okay. Is that type of housing permanent supported housing?
A I would view it as a step down, like that this individual having -- and we did discuss him previously -- having been in a nursing home, he has unique needs in that he is a double amputee. So he might need a -- a place to step down from into permanent supported housing, which is why I described that situation first.
Q So this could be -- this housing that you recommended could be an initial step, and if he did well, then perhaps some day he could go to permanent supported housing?
A Yes.
Q But in any event, the three to four-bed house you recommended, do you know how many staff members would be required to operate that facility?

A I don't. It would -- when I say staffed, that means someone who's living in and who's there 24 hours a day. So it would require at least three people.

Q Do you know how much it costs to operate such homes?

A I do not.

Q Doctor, could we turn to person 105, who's on page 141 of your report.

A I have it.

Q And everything in this next series of questions I'm going to ask you I think you'll find in the first paragraph of your report on 141. But in any event, did you interview person 105 on April 17, 2018?

A I did.

Q At the time, did she have a two-bedroom apartment in Gulfport?

A She did.

Q Did you find that apartment was very neat and very clean but sparsely furnished?

A I did.

Q And when you arrived, was person 105 cooking her own meal?

A She was.

Q At the time you interviewed her, was person 105 oriented in all spheres?

A She was.

Q And what does that mean?

A It means that she was oriented when it's in all spheres. And spheres, it's to person, place, time, other, you know, environment, everything.

Q Would you turn to page 147 of your report, please. And here you're still discussing person 105. Is that correct?

A Yes, I am.

Q All right. Aid like to refer your attention to the last paragraph on page 147. And specific -- well, and there's a sentence that begins with "specifically," do you see that?

A Yes.

Q You're welcome to follow either on the screen or in your report. But in any event, where I've got the word "specifically" highlighted, is that where -- strike that. Where the word "specifically" is highlighted, is that where you begin to identify the services that you believe person 105 needs to remain in the community?

A Yes. And before that, I say, "would have avoided or spent less time if these were available to her."

Q Okay. And so do you agree with me that that list of services continues over onto page 148 and takes up that whole page?

A Yes.

Q And do you agree with me that the list of services you identified concludes on page 149 of your report at the end of the bullet point at the top of the page?

A I do.
Q Do you believe -- based on your review of person 105, did you find at the time you interviewed her that she had created a stable life for herself in the community?
A She had.
Q And did you find that person 105 is at serious risk of institutionalization?
A I did.
Q And I think this is on page 144 of your report, if you need to verify it, but what was person 105's last discharge date from a state hospital before you interviewed her?
A 5/2/2016.
Q Which was just short of two years before you interviewed her?
A Yes.
Q Could we turn, Doctor, please, to person 111. And that person starts on page 170 of your report.
A I have it.
Q So you know who this person is and are ready to talk about person 111?
A I do.
Q Okay. Thank you. All right. Does person 111 have a history of forensic involvement?
A He does.
Q And at least briefly, what is that history?

A He has a history -- I mean, I can find it exactly -- but of assault charges, use of a weapon with the assault charges.
Q Given his history of forensic involvement, does person 111's discharge from East Mississippi State Hospital need to be approved by the discharge advisory committee?
A That was my understanding, and that's why I put it in the report, because he has unresolved forensic issues.
Q I'm sorry. Did you finish?
A Issues.
Q Thank you. Do you have any issues with patients with a forensic history having to go through a discharge advisory committee or similar process to be discharged from a state hospital?
A Do I have any issues with it, meaning would I disagree with that or I --
Q Yes.
A No, I don't disagree with that.
Q And so you made a housing recommendation for person 111, and that obviously assumes that at some point, he would be discharged. Is that correct?
A Yes. And I also assumed that he would have to -- also, his forensic issues would have to be resolved at some point as well.
Q Yes, ma'am. In your opinion, if person 111 is discharged, does he need to be discharged to a setting that is staffed 24

hours a day?
A I did make that recommendation for at least in the beginning for him.
Q And you made that recommendation because given his forensic history, person 111 is not someone you can just put into an apartment by himself?
A Correct. He also has a very likely traumatic brain injury, so there's some neurological involvement as well, which is another reason, in addition to his serious mental illness.
Q The setting you identified for person 111 that is staffed 24 hours a day, would that be a locked facility?
A I didn't put that in, I don't believe so, no.
Q Would person 111 need to be escorted when he left the facility at least for a period of time?
A It would depend on his clinical presentation and what his more recent behaviors had been. It would be an individual assessment.
Q Do you know how much it would cost to operate and staff such a facility?
A I don't.
Q I want to direct your attention, Doctor, next to person 117 in Exhibit PX-1109, which is a document you testified about earlier today. Do you recall this document?
A I do.
Q Okay. And this was -- this document was discussed in the

context of some of your testimony regarding discharge planning?
A Correct.
Q Okay. And --
A And crisis. It was also in the testimony regarding crisis.
Q My first question about this document is this. And it's right here. The date of discharge for person 117 was September 8, 2017?
A Yes.
Q And his follow-up at Pine Belt Mental Health was scheduled for four days later, on September 12th, 2017?
A Correct.
Q Is there something that -- well, let me ask -- strike that. What do you think the hospital should have done, if anything, in those four days between the date of discharge and the first appointment?
A So just so I understand your question, you're asking what the hospital's responsibility was during those four days?
Q In your opinion.
A In my opinion, and I had testified this morning that what the hospital should have done would have taken place before that, starting on August 16th. So everything would have been in place by the 8th.
Q In your experience, if a person who is discharged from a state hospital has an appointment with the mental health center within four days of his discharge, is that time lapse

satisfactory?
A Are you saying as it's -- as it is here, to send a person home and say, You're coming back in four days?
Q No, what I'm saying is, in your experience -- and I'm talking in general here. In your experience, in general, when individuals are discharged from the state hospital, they're -- they often have appointments with the local community mental health center?
A I did see that in the record, not all the time, but they were given appointments, yes.
Q And all I'm asking you is, in general, do you think a delay of four days from discharge to the appointment in the community mental health center is an unreasonable delay?
A With this individual, I think it was risky because he had two suicide attempts in the past, one very -- very, very serious, and he also is a substance use disordered person who was at risk of relapse. So a lot can happen in four days. That was my concern. When left just to you and your family being the only ones to take responsibility for the followup.
Q So in your opinion, is there any period of delay that is acceptable between discharge from the state hospital and appointment at the community mental health center?
A Can you repeat that question again, please? I'm sorry.
Q I'll try.
A Okay.

Q In your opinion, is there any period of delay that is acceptable between the date of discharge from a state hospital and the individual's first appointment at a community mental health center?

A Absolutely. It depends on what's been put in place ahead of time. You can have a delay of a week or two weeks or even longer, depending on what support services have been put in place before the person left the hospital. It depends on the individual and what their risks are, as I mentioned with this individual, but also what supports have been put in place ahead of time.

Q Based on your review of the records, do you know whether person 117 kept this appointment?

A Can you put that up again so can I see the date?

Q I'm sorry.

A I believe he did keep that appointment.

Q Do you know what happened during that appointment?

A Exactly or --

Q What information, if any, do you have of what happened during that appointment?

A I'd have to consult my report on that to see. He did, in fact, keep the appointment. He said it was mandatory. He told me in the interview that he had to pay for the visit, $25, and he was connected with services at that time, an intake assessment was done, and he was connected with services at Pine

Belt.

Q I want to move on to another topic, Doctor. In your report, did you recommend for a number of the individuals you reviewed that a close relationship be established with a dentist?

A I did.

Q And I counted that you made that recommendation for 17 of the individuals you reviewed. Is that consistent with your recollection?

A That would make sense to me, yes.

Q Are you aware of any state mental health system that provides dental care for individuals?

A I am not. I'm aware of connections being made. I'm also aware of there are dentists in communities who will provide reduced rates or free services for individuals. And my personal experience has been that mental health centers or case managers, or even within the VA it was done, to connect individuals with those dentists.

Q Have you -- let me stick with that for a minute. In those cases that you just talked about, where someone is connected with dental services, do you agree there's got to be a mechanism to pay for those services?

A Unless it's a dentist who's giving it for free, but yes.

Q Okay.

A It's a service that has to be paid for.

Q In your experience, what other ways you have seen those type of services paid for?
A Sometimes people have dental insurance. As I had indicated, a dentist will give reduced rates. There are also dental schools that will offer services, cleanings and X-rays and other services for -- because students are doing it or dental residents are providing the service.
Q Where have you seen such dental schools?
A I've seen that in Massachusetts.
Q Where in Massachusetts?
A It's the Tufts Dental School downtown in Boston.
Q Have you been retained by the U.S. Department of Justice, who I will just refer to as DOJ, in any other -- in any cases or matters other than this Mississippi matter?
A I have.
Q All right. Do you know whether the Mississippi State Hospital provides dental services?
A Am I aware if the state hospital provides it?
Q Specifically, the Mississippi State Hospital.
A What I saw in the records, and it was that there was a consult, an assessment for dental needs, and that the patients were given the choice to either go or to refuse. But often patients had serious multiple dental caries or were missing a lot of teeth, which can cause a lot of health problems. And primarily what I saw in the record was extractions. So people

ended up with less teeth, but at least they didn't have the caries.

Q You're not offering an opinion that the extractions were unnecessary, are you?

A No.

Q All right. And this is all on page 7 of your report, what I'm about to ask you next. And you're certainly welcome to refer to page 7 of your report. I'm going to refer your attention to this second paragraph here. Does it, in summary, say that in late 2014, you worked directly with DOJ on a matter in a southern state?

A I did.

Q Did you interview 106 individuals in that southern state?

A Yes.

Q And that southern state referred to in that paragraph is not Mississippi?

A It is not Mississippi.

Q Okay. So for the 106 individuals you reviewed in that southern state, did you perform a similar analysis to the analysis you performed in Mississippi?

A It was similar. It was not exactly the same.

Q Did you find that all 106 individuals you reviewed in that southern state could live in the community with reasonable community-based services?

A I don't recall. I don't recall if it was 100 percent.

Q And then you also did work for DOJ in a northwestern state. Is that correct?
A I did.
Q And did you likewise do work for DOJ in a midwestern state?
A I did.
Q I want to ask you next about -- and this is still on page 7 of your report. Top paragraph at the top of the page. Do you see the reference to *Amanda D. versus Hassan*?
A I do.
Q And was that a lawsuit in the state of New Hampshire?
A It was.
Q What was your involvement in that case?
A I was placed at a extended care facility in the northern part of the state, and I interviewed patients. I also interviewed their guardians and reviewed their records.
Q Is the facility you just referenced the Glencliff Nursing Home?
A It is.
Q To your knowledge, was a -- did New Hampshire enter into a consent degree in that case?
A I don't know what the proper terminology is for it, but I know that New Hampshire is working now on improving their mental health services, their community-based services, but I don't know the legal term for it.
Q So as far as you know, as we sit here today, this matter is

still ongoing?
A What do you mean done and gone?
Q Pardon?
A You said considered this matter what?
Q Ongoing?
A Ongoing. Okay.
Q Sorry.
A Sorry. I didn't hear you.
Q My fault.
A My understanding is that they're in the phase, that the state is in the phase of developing services, community-based services.
Q And your involvement in that matter started back in 2012?
A It did.
Q All right. And still, in reference to your involvement in the *Amanda D.* case, in that case were you asked to review what services would be appropriate to maintain the individuals in the community?
A I was.
Q Is the methodology you used in New Hampshire similar to the methodology that you used in Mississippi in this case?
A Somewhat similar, yes. Not exactly.
Q Did you interview 22 individuals who were at Glencliff at the time?
A Well, I don't have my report with me, and it was in 2012,

but that number sounds approximately right.

MR. SHELSON: Your Honor, may I approach?

THE COURT: Yes, you may.

BY MR. SHELSON:

Q Doctor, I've just handed you what's been marked as Exhibit D-289. What is Exhibit D-289?

A It's the affidavit of Judith Boardman in support of plaintiff's motion for class certification.

Q And Judith Boardman, was that your name at the time of this affidavit?

A It was. It's not spelled correctly here, but yes, that was my name.

Q Is this your affidavit?

A May I look at it a minute? Can you repeat the question now?

Q Is Exhibit D-289 your affidavit in the New Hampshire matter we're discussing?

A Yes, it is.

Q And if you would turn to the last page of exhibit -- excuse me, second to the last page, page 9 of Exhibit D-289. Is that your electronic signature on that page?

A Yes, it is.

Q And does it say the date is January 19, 2013?

A Correct.

Q All right. If I could direct your attention, please, to

page 6, paragraph 19. It's at the bottom of the page. Does this talk about the sample that was reviewed?

A Yes, it is.

Q Okay. If I turn the page, does that indicate to you that you reviewed 22 participants?

A Yes.

Q Okay. And the part I've highlighted, did you find that 22 of the 22 review participants, or 100 percent of persons reviewed, very likely would have avoided admission to Glencliff if they had access to the services sought in this case along with other existing services?

A I did write that, yes. That's my finding.

MR. SHELSON: Your Honor, we move to admit Exhibit D-289 into evidence.

THE COURT: Any objection?

MS. VAN EREM: Yes, Your Honor. We object on the basis of relevance. This document is about Dr. Baldwin's findings in New Hampshire, which is not relevant to this case.

THE COURT: Any response, Mr. Shelson?

MR. SHELSON: Yes, Your Honor. First of all, she introduced this case in her report and talks about this case to some degree in her report, and then in questioning a few minutes ago, she said that her methodology in the New Hampshire case is similar to the methodology she used here in Mississippi in this case. So we submit that this document is relevant.

THE COURT: Is this the *Amanda D.* case that's mentioned in her report?

MR. SHELSON: Yes, sir.

THE COURT: Is this -- I see in her report it's the *Amanda D. versus Hassan.* Is this the same case?

MR. SHELSON: There's -- there's --

THE COURT: Because this affidavit says *Lynn E. versus Lynch*. That's all I'm asking.

MR. SHELSON: Well, as I understand it, there's *Lynch* and *Amanda D.*, and they're related cases.

THE COURT: Are they related cases, or are they the same case? That's the only question that I have. Maybe Ms. Boardman can -- well, the United States was involved and -- are these the same -- I'm just trying to figure out. The expert report that's in evidence in this case from Dr. --

MR. SHELSON: Baldwin.

THE COURT: -- Baldwin mentions an *Amanda D. versus Hassan* case out of New Hampshire. The affidavit that she's been presented with today is an affidavit that was filed in *Lynn E. versus Lynch*, and the United States being an intervenor against the State of New Hampshire. Are those the same two cases is my question?

MS. VAN EREM: Yes, Your Honor. They are the same case.

THE COURT: Okay.

MS. VAN EREM: Your Honor, if I may, I maintain that this is irrelevant because there's no facts in this case that is more likely to be established with the introduction of this document.

THE COURT: It's hearsay. That's one thing it is. I know that.

MR. SHELSON: Well, with that point, Your Honor, they can correct me if I'm wrong, but the United States objected to a number of the State's exhibits. One of the United States' objections to the exhibits that they objected to in many instances included hearsay. And my understanding is that the United States has withdrawn its hearsay objections to the State's exhibits.

MS. VAN EREM: That's correct. We maintain our objection on relevance and Federal Rule of Evidence 403.

MR. SHELSON: Your Honor, on the point about relevance, if I may, we think it is relevant that where the two instances that we have data that Dr. Baldwin has used the methodology she used in Mississippi, she's found that 100 percent of the people in Mississippi and 100 percent of the people she reviewed at Glencliff in New Hampshire very likely would have avoided admission if they had received sufficient community-based services.

THE COURT: I'm going to overrule the objection.

I presume it just goes to the point that in this case,

as well as the other case, 100 percent of the people she reviewed, she came to the same conclusion basically.

MR. SHELSON: Yes, Your Honor. May I?

THE COURT: You may proceed.

MR. SHELSON: Thank you, Your Honor.

BY MR. SHELSON:

Q Going back, Dr. Baldwin, to your finding that 100 percent of the people you reviewed in Mississippi would have avoided or spent less time in the state hospital, what is your scientific basis for that conclusion?

A And what do you mean by scientific exactly?

Q Well, I'm trying to remember back to this morning. You were tendered as an expert in the field of what? Do you recall?

A Psychiatric nursing.

Q Is there scientific basis for that conclusion in the field of psychiatry or psychiatric nursing?

A I guess I'm still not understanding scientific. If you -- what I based that on was more my understanding of what community-based services work for people that are very -- that I've seen work for people who are very similar to the people who were in my sample. And I've them avoid hospital or spend much less time in hospital when those services are being provided to them effectively.

Q The rates at what you -- that -- strike that. The rates at

which you have seen community-based services help people avoid hospitalizations, are those rates in line with the rates reflected in Dr. Drake's paper that we looked at earlier that's Exhibit D-235?

A I can't say the percent of rates. I know that the services that are listed here on the ones I've talked about are effective, but I can't quote rates. He has done a review of the literature and looked at a series of articles, not all, I'm sure, and has put together a summary. It was used as a guide.

Q Do you have any different rates based on the literature that you can offer the court?

A No.

Q In your opinion, can everyone benefit from community-based services?

A When you say everyone, I mean, I would like to say in general or most everyone. I don't want to say everyone who has serious mental illness can always benefit. I'm reluctant to do that.

Q I'm going to refer you, Doctor, to page 147 and page 148 of your deposition. This highlighted part, I asked you, "Are there instances where an individual would not benefit from integrated community-based services?" And your answer was, "Of the sample or in general?" I said, "In general." And what was your answer?

A I said, "In my opinion, no. I think everyone can benefit."

Q You were not asked in this case to determine whether Mississippi is offering reasonable community-based services, were you?
A I was asked -- my task was to answer the questions that I had testified to this morning. So not to -- what did you say? Make a determination on whether the State is --
Q Offering reasonable community-based services.
A I was not asked to do that, no.
Q To your knowledge, does any state have a clinical review team review a random sample of individuals discharged from a state hospital to determine what community-based services it needs to offer on that basis?
A To my knowledge, is any state doing that now? Is that what you're asking?
Q Yes.
A No, I have no knowledge of that.
Q To your knowledge, has any state ever done that?
A So ask the question again. Has any state ever --
Q Had a clinical review team review a random sample of individuals discharged from state hospitals and determined what community-based services it needs to offer on that basis?
A That the state commissioned to do that, you're saying?
Q Yes.
A No, not to my knowledge.
MR. SHELSON: Can I have a moment to confer, Your

Honor?

THE COURT: Yes, you may.

BY MR. SHELSON:

Q Doctor, did you make any determination regarding how many PACT teams Mississippi should have?

A No, I didn't.

Q Did you make any determination regarding what quantity of any community-based service Mississippi should have?

A No.

Q Did you make any determinations regarding what locations Mississippi should offer its community-based services in?

A Do you mean geographic locations?

Q Yes.

A No, I did not.

Q Do you have an opinion regarding whether the community-based services that Mississippi does offer are reasonable in light of what other states offer?

A I do not.

MR. SHELSON: Your Honor, that's all the questions we have. Thank you, Dr. Baldwin.

THE COURT: All right.

MS. VAN EREM: The United States has no further questions.

THE COURT: Dr. Baldwin, I have no questions either. You may step down. Is this witness finally excused?

MS. VAN EREM: Yes, Your Honor.

THE COURT: All right. You may step down and go about the rest of your duties, whatever they are. Thank you.

Before the government calls its next witness, we're going to -- the next witness is an expert?

MS. VAN EREM: That's correct.

THE COURT: Okay. We're going to take a 15-minute break, and we'll figure out how far -- how long we'll go with that person. We'll be able to tell you when we get back.

(Recess)

THE COURT: Good to have you back, Mr. Holkins.

MR. HOLKINS: Good to be back, Your Honor.

THE COURT: All right. I mentioned the possibility of those posttrial proposed findings of fact, and I haven't seen Ms. Fox since. Maybe she's doing them now. I'm sorry. We have to do things to stay -- you know. Are we ready to call the next witness?

MR. HOLKINS: Yes, Your Honor.

THE COURT: All right. You may proceed.

MR. HOLKINS: Your Honor, United States calls Katherine Burson as its next witness.

THE COURT: Ms. Burson, I'm not sure if you've been in the courtroom when I've given instructions, so if you will, speak into the microphone, and speak at a pace at which the court reporter can keep up with you.

Try to allow the lawyers to complete their questions or their statements before you speak so that the two of you will not be speaking at the same time. We are now unplugged, apparently. We're good? Okay.

Make sure all of your responses are verbal. If you're going to nod or shake your head, say yes or no, and we'll try to traffic that in case -- that that doesn't happen. And try to avoid using uh-huh and unh-unh. Also, if you will state and spell your name for the record.

THE WITNESS: My first name is Katherine, K-A-T-H-E-R-I-N-E. And my last name is Burson, B as in boy, U-R-S-O-N.

THE COURT: Thank you. Counsel, you should not feel rushed today. It's likely that this will be our last witness, obviously, and we may only get through her direct today, if it's anything like some of the other -- I mean, I don't know. Is this witness available tomorrow?

MR. HOLKINS: Yes, Your Honor.

THE COURT: Is she? Are you, Ms. Burson?

THE WITNESS: Yes, I am.

THE COURT: Okay. All right. We may hear the rest of the story tomorrow. All right. You may proceed, Mr. Holkins.

MR. HOLKINS: Thank you, Your Honor.

KATHERINE BURSON,

having first been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. HOLKINS:

Q Good afternoon, Ms. Burson.

A Good afternoon.

Q What do you do for a living?

A I'm an occupational therapist.

Q Were you retained by the United States to consult on this case?

A Yes, I was.

Q What did your work on this case entail?

A I was asked to interview a number of individuals that were receiving services in Mississippi, mental health services, and to make a determination, after reviewing their medical records and other information that I gathered, as to whether or not I thought that they could have avoided or spent less time in the hospital.

Q For how many individuals did you make that determination?

A I did that for 28 individuals.

Q Did you submit an expert report in this case?

A I did.

MR. HOLKINS: Your Honor, Ms. Burson's expert report was previously admitted as PX-406. A copy of her report is in the binder provided to the court and opposing counsel.

THE COURT: Okay. Thank you.

BY MR. HOLKINS:

Q Ms. Burson, does your report state the findings and conclusions you made based on your review of those 28 individuals?
A Yes, it does.
Q We'll discuss your report in detail, but first I have some questions about you. What does an occupational therapist do?
A An occupational therapist, the domain of occupational therapy practice is all the everyday occupation things that we do that occupy our time. So all the things that we need to do and we want to do. And an occupational therapist is educated to assess and analyze all of the factors that influence a person's ability to do what they need and want to be able to do.
Q And what are some of those factors that influence a person's ability to do what she needs or wants to do?
A Okay. So they can be factors that have to do with a specific individual, how their body works, how their brain works, what kinds of illnesses and conditions they have, their personality, what their interests are, what their strengths are, what their challenges are, so those are person level things. It also has to do with the task demands people have to do. So properties of the tasks or the roles, the things that people have to do, we analyze those.
The environment, the context within which they have to do those things, we are taught to analyze that, and then we look

at the interaction amongst those things. And all of those are points of potential intervention to help somebody be able to do what it is they want or they need to be able to do to function better.

Q Do occupational therapists prescribe medication?

A No, they do not.

Q Do occupational therapists assess the effects of medication on a person's functionality?

A Medications would be amongst the factors that we would consider in that analysis of things. So, for example, if someone is particularly groggy, and I look and what medications they are on could contribute to that grogginess, then I would have a conversation with the psychiatrist or the nurse practitioner about that, and we would, you know, make some determination with the individual about the degree to which that might be impacting the function.

Q What licenses and certification do you maintain?

A I have a -- an Illinois license to practice occupational therapy. I also have a national board -- board certified occupational therapist nationally. And then I also have a national certification for certified recovery -- certified rehabilitation -- certified psychiatric rehabilitation practitioner. Thank you. I was going over the acronym in my head.

Q What is the certified psychiatric rehabilitation

practitioner?
A That's a cross-professional, cross-discipline certification that focuses on implementation of practices that promote hope and empowerment and the kinds of things that help someone take more charge over their lives and move forward.
Q How long have you been working in a mental health field as an occupational therapist?
A Since 1980 was my first clinical practicum in mental health, and then I've practiced since them.
Q How would you describe the overarching focus of your career in the mental health field?
A My career has always ended up, for whatever reasons, focusing on what was needed to help people be able to live more successfully in the community. Much of that career, I did practice in hospital settings, but the focus of that was on helping people be able to function better outside of the hospital.
Q You have a master's degree in occupational therapy. Is that right?
A Yes, I do.
Q Where did you obtain that degree?
A I went to Washington University in St. Louis, Missouri.
Q Organizing them into broad categories, how would you describe the kinds of jobs you've had since completing your occupational therapy training?

A So I've had a number of jobs providing direct care where I carried a full patient case load and did the assessment on people and provided treatment and participated in treatment planning meetings and in team collaboration.

And then I've also had jobs where I provided -- I provided direct care, but I also supervised other clinicians who provided direct service. And then I've also had jobs that have been in the hospital and have been in the community. I've worked in the full continuum of care.

Q Let's talk a bit about your direct clinical care work. Could you briefly describe the roles you've had providing clinical services to adults with serious mental illness in hospital settings?

A Yeah. One of the roles is assessment, particularly assessment of somebody's ability to function and to be able to look at how their ability to function influences those patterns and behaviors that seem to drive hospitalization and -- so that those can be factored in to the discharge planning and to the community supports that are provided.

Another role that I've had has been to look at how to engage somebody who doesn't seem to be making a connection to treatment or is too sick at the time to connect verbally.

Q You have worked in a state hospital before?

A Yes, I have.

Q Which one?

A Chicago Read Mental Health Center.
Q After you have left Chicago Read Mental Health Center, did you continue to work for the State of Illinois?
A Yes, I did.
Q What other jobs have you had for the State of Illinois?
A So while I was working at Chicago Read Mental Health Center, I had led efforts to better coordinate the care between -- the rehabilitation care between the hospital and all of the community providers. So they asked me to then start to work for not only the state hospital but all of the network of community mental health agencies that were providing community services to people who were hospitalized there. So I took the lead role for rehabilitation then there.

And then after that, they asked me to do that for the Greater Chicago area, which was then three hospitals and about 80 to 90 community mental health agencies. And then they asked me to take the lead for that statewide. So that was eight hospitals and about 180 community mental health agencies.
Q For a period of time, did you serve as statewide director of rehabilitative services for the state of Illinois?
A Yes, I did, for somewhere between 10 and 12 years.
Q And what were your duties in that role?
A One of the things that I did is I brought to Illinois evidence-based supported employment, to drive that in the community system. I eventually became the lead person for

driving evidence-based practices in the state, and I also had oversight of rehabilitation within the state hospitals and the larger community system.

Q Ms. Burson, do you still work for the State of Illinois?

A No, I do not.

Q When did your employment for the State of Illinois end?

A In March of 2017.

Q Have you had any involvement in administering Illinois' mental health service system since then?

A No, I have not.

MR. HOLKINS: Your Honor, we offer Katherine Burson as an expert in psychiatric occupational therapy, serious mental illness, and community-based mental health assessments.

THE COURT: Any objection from the State?

MR. SHELSON: Sorry. Can I have those three again?

MR. HOLKINS: Psychiatric occupational therapy, serious mental illness, and community-based mental health assessments.

MR. SHELSON: No objection, Your Honor.

THE COURT: All right.

MR. HOLKINS: Your Honor, may I have a moment.

THE COURT: Yes.

(Short Pause)

MR. HOLKINS: May I approach the witness.

THE COURT: Hold on one second. You may. You may

approach the witness. The witness will be allowed to testify as an expert in psychiatric occupational therapy, serious mental illness and community-based mental health assessments.

MR. HOLKINS: Thank you, Your Honor.

THE COURT: You may proceed.

BY MR. HOLKINS:

Q Ms. Burson, I'd like to ask you some general questions about the review you conducted in this case. You stated earlier that your review involved making clinical assessments of 28 individuals who received services in one or more of Mississippi State Hospitals. Is that correct?

A Yes.

Q What were you assessing for those 28 individuals?

A I was asked to assess whether or not they could have avoided or spent less time in a state hospital. I was asked to assess, if they were out of the state hospital, whether they were at serious risk for rehospitalization. I was asked to assess whether or not they would oppose community-based services. And I was asked whether or not they were appropriate for community services, and if so, which services did I think would be most appropriate to address their needs.

Q Ms. Burson, please turn to page 4 of your report, which is at the tab labeled 0406. Is this where you explain how you approached those four questions?

A Yes.

Q Ms. Burson, do you have a demonstrative that summarizes your findings with respect to the 28 individuals you reviewed?
A Yes, I do.
MR. HOLKINS: May I approach, Your Honor.
THE COURT: Yes, you may.
MR. HOLKINS: Your Honor, this first slide is PDX-19 for identification only.
THE COURT: All right.
BY MR. HOLKINS:
Q Ms. Burson, does this slide accurately reflect your findings?
A Yes, it does.
Q Let's go through them one by one. On the question of whether the individuals in your review could have avoided or spent less time in a state hospital, what did you find?
A I found that 100 percent of them could have avoided or spent less time in a state hospital.
Q On the question of whether the individuals in your review opposed receiving community-based services, what did you find?
A I found that 100 percent of them would not oppose community-based services.
Q On the question of whether the individuals you reviewed were at serious risk of hospitalization, what did you find?
A I found that of the people that were out of the hospital at the time that I interviewed them, that 88 percent of them were

at serious risk of rehospitalization.

Q On the question of whether the individuals in your review were appropriate for and would benefit from community-based services, what did you find?

A I found that 100 percent of them would be appropriate for and benefit from community-based services.

Q What data informed your review of the 28 individuals in your report?

A I interviewed all 28 individuals. I also reviewed all of the medical records that were made available to me, which included the medical records from the state hospital, as well as, in many cases, community mental health records. I reviewed the Mississippi operations manual, their service definitions for mental health services in the community and what was entailed with those, and reviewed some information on the housing program. And then I also reviewed -- Dr. Robert Drake had pulled together a summary of research of practices that had been shown in the research to reduce hospitalization, and I reviewed that document as well.

Q Ms. Burson, did you also interview any family members or community mental health providers in connection with this review?

A Yes, I did. Whenever I was able to, I interviewed quite a number of family members, and I also interviewed community mental health agency staff about individual clients.

Q How did you go about locating the 25 individuals you interviewed who were not in a state hospital at the time?
A So I came to Mississippi, and persons from the Department of Justice had identified information of where people might be located and tried to reach out to them, and we drove around in cars trying to find them. We knocked on doors. Sometimes we had appointments. Sometimes they weren't able to reach someone, so we would go to the most recent address that we had. But we went around looking. And so I was in four different areas in the state.
Q Were you able to find all of the individuals you were looking for?
A No, we did not find all of the individuals that we were looking for.
BY MR. HOLKINS: Did you interview some of the 28 individuals in your review jointly with another member of the clinical review team?
A Yes. The first time I came into Mississippi, we did a number of interviews where we had two people on the clinical review team in the same interview. One person took the lead, and one person was a secondary interviewer. And we did that so that we could see whether or not we would have drawn the same conclusions.
Q Ms. Burson, I'm going to be referring to the 28 individuals you reviewed by numbers instead of by their names. Do you

understand?
A Yes, I do.
Q I've given you Exhibit 400, which is a list of all 154 people in the clinical review, along with the number. Do you have that?
A I don't see it. Where would it -- do you know where it would --
THE COURT: It's your second tab probably in that notebook.
THE WITNESS: Thank you. I do have it.
THE COURT: Okay.
MR. HOLKINS: Thank you, Your Honor.
THE COURT: All right.
BY MR. HOLKINS:
Q Ms. Burson, let's return to the four questions you answered for the 28 individuals in your review. The first of those four questions asked whether the individual could have avoided or spent less time in the state hospital. Is that right?
A Yes.
Q As a practical matter, what did you mean when you found that individuals could have avoided the state hospital?
A What I was looking at was if there -- if they had had services provided that have been shown to mitigate the risk of hospitalization, were those services sufficient to help mitigate that risk. And then I also looked at if there was

evidence in the medical record that they had been in the hospital longer than they -- than the medical record said they had stabilized.

Q How does your finding that some individuals could have avoided hospitalization compare to a finding that those individuals never needed inpatient treatment?

A I don't see those as the same determinations. So for me -- when I look at something, someone could need hospitalization at the point in time that their symptoms have already escalated to the point that they need to get hospital-based treatment to get -- to right the ship. So -- but I looked in those cases as to what the community services were that they had prior to that hospitalization and leading up to that, and whether those services, based on their normal or their typical pattern of what happens before they get hospitalized, whether the services that they were prescribed and receiving were sufficient to mitigate the risk.

Q In some instances, did you find that the services being received were not sufficient to prevent hospitalization?

A Yes.

Q What kinds of community-based treatment did you find the individuals you reviewed needed to avoid hospitalization but did not receive?

A I found the PACT, Program of Assertive Community Treatment, was not their supportive employment, permanent supportive

housing, community support services, mobile crisis supports, more intensive transition services out of the hospital.

Q Could you briefly describe what PACT is?

A Uh-huh. Yes. PACT is a team-based approach to providing --

MR. SHELSON: Objection, Your Honor. This is just repetitive at this point. I think we all know what PACT is at this point in the trial.

THE COURT: All right. We can -- I'm fully versed in what PACT is. So --

MR. HOLKINS: Okay.

THE COURT: All right.

MR. HOLKINS: Thank you, Your Honor.

BY MR. HOLKINS:

Q Ms. Burson, could you give an example of one in your review who needed PACT but didn't receive it?

A Person 133.

Q How would you describe person 133?

A He's an African-American male in his mid 30s. He lives in a trailer on his sister's property. He has kind of bounced around, living with his mother sometimes, sometimes with his sister on the property. He has a remote work history, used to work at a chicken plant. He's done some car detailing, but he hasn't worked in quite some time. He has very little structure to his day and has been in the hospital a lot.

Q Could you please turn to page 76 of your report, which is 406. Is this where you discuss person 133?
A Yes, it is.
Q Where did you interview this individual?
A I interviewed him at Mississippi State Hospital. He was actually hospitalized at the time of the interview.
Q At the time you submitted your report, how many times had this individual been admitted to state hospitals in Mississippi?
A He had been admitted there 16 times.
Q Ms. Burson, do you have a demonstrative showing how much time person 133 spent in a state hospital over a one-year period in 2017 and 2018?
A Yes, I do.

MR. HOLKINS: Your Honor, this is PDX-20 for identification only.

THE COURT: PDX-20?

MR. HOLKINS: Yes, Your Honor.

THE COURT: All right.

BY MR. HOLKINS:
Q Ms. Burson, what time period does this demonstrative cover?
A May of 2017 through April of 2018.
Q How many state hospital admissions did person 133 have during that one-year period?
A Four.

Q How were those hospitalizations identified on this demonstrative?
A Each hospitalization is denoted by a different color that is blocked in on the calendars.
Q In the first four months of 2018 alone, how many times was person 133 in a state hospital?
A Three.
Q And during those four months, did person 133 spend more time in a state hospital or not? Over those four months, did person 133 spend more time in a state hospital or not in a state hospital?
A He spent more time in the state hospital than outside of the state hospital.
Q Did this man's state hospital admissions between May 2017 and August -- excuse me, April 2018, follow a pattern, or was each one different?
A They followed a pattern.
Q Do you have a slide that shows the pattern you observed?
A Yes.

MR. HOLKINS: Your Honor, this is PDX-21 for identification only.

THE COURT: All right.

BY MR. HOLKINS:
Q What is the title of this demonstrative, Ms. Burson?
A Person 133, "Cycle of State Hospitalization Admissions."

Q How many steps are there in that cycle?
A Four.
Q Let's walk through them. What's the first step in person 133's cycle of state hospital admissions?
A So in the first phase, he is living in the community without adequate community mental health services.
Q What does community living look like for person 133?
A So he's living in a trailer on his sister's property that's in pretty bad shape. He is -- has no structure to his day. He doesn't really have any steady kinds of responsibilities of what he needs to do. He typically doesn't take his medications consistently, uses substances, can -- when he's using substances can get irritable and moody and disruptive and difficult to be around.
Q What happens next in the cycle?
A Eventually, he tends to go off of his medications completely, uses more substances. He's more disruptive. He escalates. His family finds him so disruptive and out of control that they push for hospitalization.
Q Did you see any evidence that person 133 received crisis services in that stage?
A No, I did not.
Q And what happens in step 3?
A So in step 3, he gets admitted to the state hospital. And when he's at the state hospital, he tends to stabilize pretty

quickly on medications. He's engaged in the groups and the various therapies that are offered there, and he is prepared for discharge.

Q And finally, what's step 4 in this cycle of state hospital admissions for person 133?

A So in step 4, then he is discharged from the state hospital with ineffective discharge planning.

Q In what ways is the discharge planning that person 133 has received in the state hospital ineffective?

A The discharge plan doesn't provide a way to address the factors that keep driving the repeated hospitalization. So I would expect with discharge planning, when a plan hasn't worked and someone keeps getting hospitalized, that they would be looking for an alternative plan that would address the factors that keep driving the hospitalization.

So what happens then is he goes out there, he doesn't get those kinds of services, and the cycle repeats itself.

Q Why did you recommend PACT for person 133?

A He meets the criteria for PACT. He's sort of a classic referral for that. He's had repeated hospitalizations. He has a comorbid substance use condition that goes along with that. He can get very disruptive and sometimes end up getting into legal involvement around -- for things like disturbing the peace. And PACT has the capacity to intervene in all kinds of ways that would help break up that cycle.

Q Have you seen individuals like person 133 who are able to avoid hospitalization once connected to PACT?
A Yes.
Q At the time of your review, had person 133 ever received Program of Assertive Community Treatment?
A No, he had not.
Q Why not?
A It was not available in the area where he lived, but I don't think it was ever -- it was -- there was no evidence that it was ever considered or that they tried to put together a more intensive sort of even PACT-like sort of thing.
Q In stepping back from person 133, how many people of the 28 in your review were receiving PACT at the time?
A One.
Q Who is that person?
A Person 142.
Q How would you describe person 142?
A So he's an African-American male in his mid to late 50s. He lives in his own home, which he's had for quite some time now, something in the vicinity of 12 years. He was in college at one point in time to become an electrical engineer. He didn't end up completing that education, but he did end up going, despite a long history of illness, completing some certificates in related fields at the community college. So he has some certificates around to repairing different kinds of

electrical equipment. And he has a couple of those in TV repair and radio repair and those kinds of things. His house is filled with various kinds of equipment that he would like to get back to repairing some day.

Q Could you please turn to page 124 of your report? Is this where you describe person 142?

A Yes, it is.

Q At the time you interviewed him, how many times had person 142 been admitted to a state hospital in Mississippi?

A He has had ten hospitalizations at Mississippi State Hospital. He's also had several other psychiatric admissions, but ten at the state hospital.

Q In general, what have been the factors contributing to these man's repeated state hospital admissions?

A He has -- he often also goes off of his medications. He stops taking them. He has a comorbid medical condition. He has diabetes that he has alongside of that and often has difficulty managing that diabetes, and there's an interaction, and then that can spiral things. He -- when he goes off his medications, he gets manic-like. He's been known to go out and buy cars. He's gotten into bankruptcy issues. He's -- he gets in trouble for disturbing the peace.

Q When did person 142 start receiving PACT?

A In 2015.

Q What services does person 142 receive through PACT?

A He has people regularly coming out to his home to help him. He gets support around medications, in making sure and working with him around taking medications. He gets support around following his diet and managing his diabetes.

He also is involved with peer support, and he -- they also pick him up and take him to a center where he can take, you know, wellness classes and does some fitness kinds of things.

Q What do you -- first off, how many times has person 142 been admitted to state hospitals in Mississippi since 2015, when he connected to PACT?

A He was admitted once since 2015. But prior to that, in the few years from 2011 until 2015, he was hospitalized a total of 17 times. There were four of those that were at Mississippi State Hospital, I believe.

Q What do you make of the fact that person 142 went back into the state hospital even after he started receiving PACT?

A I think that that is not uncommon. When somebody's had so many hospitalizations, sometimes it takes awhile before they never get hospitalized. Still, in that particular hospitalization, he went his longest period of time since 2011 without being hospitalized, and it was his shortest hospitalization.

And additionally, there was some significant stressors that contributed to the hospitalization. So he had previously a brother who was killed in an auto accident and that he was

very -- he's very, very close and connected with his family. And prior to that 2017 hospitalization, the one since he was on PACT, his other brother was diagnosed with cancer. So there were some things going on.

Q Let's turn back to person 133 for a second. How would you compare person 133's history of hospitalization with that of person 142, whom we just discussed?

A I think their history of hospitalization is similar in that they both have a pattern of going off of their medications. They both have additional medical conditions, and one having the substance use issues, but the other one having the diabetes that's difficult to manage, and that has some interaction effects.

They both get disruptive and out of control and get into all kinds of trouble when they -- that escalates into requiring hospitalization.

Q What distinguishes them?

A Well, person -- one person got PACT, and one did not. And the cycle stopped when the one person got PACT, or certainly was significantly altered.

Q Ms. Burson, I'd like to shift to another finding from your review. You testified that many of the individuals you reviewed were at serious risk of further hospitalization at the time. Is that correct?

A Yes, I did.

Q How did you go about determining that these individuals were at serious risk of rehospitalization?
A I looked at -- after collecting all the information from the interviews that I did with the community mental health agencies and the family members and the individuals and reviewing all of their medical records, I looked for what were the patterns -- what was happening before people were hospitalized. I looked at what kinds of services they were getting, and I looked at whether or not the services that they were receiving at the time that I interviewed them, and based on how they were doing, were they receiving services that would help mitigate that risk.
Q In general, what's the extent of the community-based services that these at-risk individuals were receiving at the time of your interviews?
A I'm not sure I heard your question. Could you repeat it? I'm sorry.
Q In general, what was the extent of the community-based services that these at-risk individuals were receiving at the time of your interviews?
A In general, they were receiving very little services. For the most part, people were prescribed medication services. Some people were getting some very minimal community support, but most of the people were not getting that either. So the treatment was predominantly focused on medications with some

community support for some individuals.

Q What were the obstacles to receiving appropriate community-based services for these at-risk individuals?

A Well, in some cases, the services that would have been -- that would have addressed the factors that were contributing to their hospitalizations were not available where they lived. In other cases, the services that they needed might have been available to them, but for whatever reason, those services were either not considered or not prescribed. The person wasn't receiving them.

And then in some cases, the person was receiving the service, but not with the intensity or the frequency that would mitigate the risk.

Q What are some examples of community-based services that were not available in some individuals' home counties?

A PACT and supported employment.

Q And what are examples of community-based services that were available to at-risk individuals which they never received?

A Permanent supportive housing.

Q Finally, what services did you find that these at-risk individuals were receiving, but not with the intensity necessary to prevent hospitalization?

A Community support services.

Q Ms. Burson, I'd like to drill down on one of the services you mentioned, supported employment, which you testified that

individuals at risk of hospitalization needed but weren't receiving. Correct?

A Yes.

Q Could you give an example of one such individual?

A Person 132.

Q Could you briefly describe person 132?

A Yeah. Person 132 is a 23-year-old very fair-complected Caucasian male. He's also quite overweight. He graduated high school. He grew up in and out of foster care. His mother has schizophrenia. He -- he lives with his mom and his -- he's got a four-year-old brother.

He did graduate high school, despite being sick and having mental health challenges from a young age, his teens. And he even started college. He really likes science, biology, especially anything having to do with the ocean, and he likes history, and especially anything having to do with the Civil War. But college was -- he got interrupted with -- he was getting sick so often, so he stopped going to college. And then he worked at McDonald's, and he's worked at Sonic, and he's done that, but that's kind of who he is.

Q Could you please turn to page 81 of your report. Is this where you discussed person 132?

A Yes, it is.

Q Where did you interview him?

A I interviewed him in the home that he lives in with his

mother, though he was the only one. You know, his family was not present at the time of the interview.

Q At the time of your interview, how many times had person 132 been admitted to state hospitals in Mississippi?

A In Mississippi, he was in the state hospital three times. Prior to that, he had lived in Louisiana.

Q What community-based services did you recommend for person 132?

A I recommended PACT and permanent supported housing, and I recommended that PACT also have an emphasis on supportive employment.

Q Why did you think person 132 was a good fit for supportive employment?

A He wants to work. He had worked for about a year at McDonald's, and then -- this was in Louisiana. And then he worked for another year at Sonic, and then he moved to Mississippi. And he worked at another Sonic for about six months, and then he lost his job. He was told when he was let go that he was making the other employees uncomfortable because he was scary.

And supported employment is an intervention designed to help with that, to keep people working. Since that time, he has not tried to work.

Q How would person 132 benefit from supported employment?

A So supported employment does all kinds of things for people

besides giving them a paycheck, which, of course, is good, but it also gives them a sense of their identity, and an identity other than being a patient or a person with a significant illness. It gives them structure to their day. It gets them up and out of bed to go where they need to be. Many people end up taking better care of their appearance. It gives them a way to interact with other people in the community and gets them rooted to their community. It keeps them more physically active.

For many people, it means that they build in -- it gives them a reason to take their medications. It gives them a reason -- you know, there's something to lose by being hospitalized. The list goes on and on and has many, many positive -- employment has many, many positive benefits for people. You see it both ways, but it's supported with an ED.

Q Returning to person 132, why did you find that he was at serious risk of rehospitalization?

A When I interviewed him, and at the time he was not receiving services that would mitigate his risk for hospitalization. Additionally, he -- he talked with me about how it was a time of year when he was typically hospitalized, kind of knows his pattern of when he gets hospitalized. And in talking with him, he had no sense of what he could do or a plan to help prevent that in any way.

Q How would the community-based services that you

recommended, including PACT and supported employment, help to mitigate the risk of hospitalization for person 132?

A So there's a few ways that he gets hospitalized. One thing, he has a history of going off of his medications, so PACT would help him, you know, ensure that he is getting his medications consistently.

He also doesn't have a sense that he can -- he doesn't have much of a sense of self-agency at all, that he can manage his illness, and PACT can get in there and work with him on what he can do to help do that. And PACT can do that in his natural living environment.

I mentioned before that he's actually quite obese, and he's got some health things related to that at a very young age of only 23. So a nurse and a team can also help give him some guidance around that and start to build greater independence in him. He's --

Q At the time that you interviewed him, had person 132 ever received PACT?

A No, he had not.

Q At the time you interviewed him, had person 132 ever received supported employment?

A No, he had not.

Q Ms. Burson, were any of the individuals in your review whom you recommended for supported employment actually receiving the service?

A No.
Q Ms. Burson, I'd like to shift gears and talk about permanent supported housing, which is the service you testified that at-risk individuals in your review didn't receive, even though it was available. Is that correct?
A Yes.
Q Could you give an example of one such individual?
A Person 125.
Q Could you briefly introduce person 125?
A He's a very tall African-American male in his mid 30s. He stood the whole time of the interview. He's got a restlessness and agitation about him. At the time of the interview, he was actually watching a young nephew and was able to keep his eye on his nephew to make sure he wasn't getting into something that would put him in danger, though he was still quite distractable with tangential speech and some other kinds of symptoms.

He used to work -- he actually dropped out of high school when he was 15 because his mother passed away, and he describes having dropped out for financial reasons to be able to help support the family.

He used to work as a commercial truck driver and as a commercial fisherman, although he hasn't worked for some time now. He lives with his uncle.

Q Could you turn to page 20 of your report, please. Is where

you discussed person 125?
A Yes.
Q At the time you interviewed him, how many times had person 125 been committed to state hospitals in Mississippi?
A Three.
Q At the time you interviewed him, when was person 125's most recent state hospital discharge?
A His most recent state hospital discharge was October 14th of 2017.
Q Ms. Burson, what community-based services did you recommend for person 125?
A PACT and permanent supported housing.
Q Ms. Burson, please turn to the tab labeled PX-1103. What is this document?
A This is his most recent discharge summary from South Mississippi State Hospital.
Q And you are referring to person 125?
A Yes, I am.
Q This is in connection with his most recent state hospital discharge. Is that right?
A Yes.
MR. HOLKINS: Your Honor, I'd move this into evidence as PX-1103.
THE COURT: Any objection from the State?
MR. SHELSON: No, sir.

THE COURT: PX-1103 is received in evidence.

(Exhibit PX-1103 marked)

BY MR. HOLKINS:

Q Ms. Burson, on the first page of this document, please direct your attention to the section titled "History of present illness." Do you see that?

A Yes.

Q Could you read that section aloud?

A "The patient is a 36-year old black male. He's been off of his psychotropic medications for months, possibly a year. He has become paranoid with his family, convinced they are putting poison in his food. He has lost 20 to 30 pounds and eats only fast food from outside of the home. Further, he is convinced they put a satellite in his head, have conspired against him to get his money. He states, quote, My uncle is the ring leader, unquote. He acknowledges this has caused him worry and agitation, leading to decreased sleep, et cetera, and racing thoughts, poor concentration and hyperactivity. The patient was admitted to Singing River Hospital, where he has improved with some treatment with Risperidone. He is agreeable to further treatment."

Q Ms. Burson, where was person -- Ms. Burson, where was person 125 discharged after this admission?

A Into that same uncle's home.

Q Are you referring to the uncle described as the ring leader

in person 125's discharge summary?

A Yes, I am.

Q Why did you recommend this individual for permanent supported housing instead of placement with his uncle?

A So permanent supportive housing is a good intervention for somebody that has housing instability that contributes to their need for hospitalization or a person who's living situation contributes to their need for hospitalization. And in his case, because -- although he's quite actually connected with his family, his family and this uncle, but his family gets very interconnected and intertwined into his delusions, and that escalates his symptoms even further and drives hospitalization.

So I thought it would be better for him to mitigate that risk by having him not live with his family but still live near enough to his family that he can be connected to them.

Q What would permanent supported housing look like for person 125 as a practical matter?

A So he would have his own apartment or home. Often it comes with a rental subsidy. And then he would get supports to help make sure he's maintaining that home and doing the things you need to do to be a good tenant. And, you know, it would go with PACT.

The other thing that would do is he would have his own food supply. When he gets more symptomatic, he wouldn't be worrying about whose food it was that was in the refrigerator and

whether his family was trying to poison him. And also, what permanent supportive housing can do for someone like him is provide a safe place to deescalate when his symptoms do start to ramp up.

Q When you interviewed him, had person 125 ever received permanent supported housing?

A No, he had not.

Q Had he ever received PACT?

A No, he had not.

Q I'd like to shift gears and talk about discharge planning. In general, how would you describe the discharge planning services the 28 individuals in your review received in Mississippi's state hospitals?

A In general, I found the discharge planning to be inadequate.

Q Why did you find it to be inadequate?

A So discharge planning -- a reasonable standard for discharge planning would be that the discharge plan is individualized, that it takes into account the factors that have been driving hospitalization and tries to do something to mitigate those factors.

Another reasonable standard would be that it is collaborative and that it is coordinated to ensure follow-through. And the other one would be that if in the past a discharge plan that you put in place didn't work, that you

would analyze that and figure out what didn't work about it and try something different.

Q So you've described what you termed a reasonable standard for discharge planning. Correct?

A Yes.

Q And how does that compare with what you saw for the 28 individuals in your review?

A So, in general, I found the discharge planning to be formulaic. People pretty much got the same discharge plan, and it -- I didn't see discharge plans change, even when in the past the discharge plan hadn't worked. I didn't see, in general, that -- for example, so many people had a consistent pattern of going off of medications, and I didn't see services prescribed that would look at the reasons why they were going off medications and try and do something to intervene with that. So they would still prescribe medications, for example, medication services, but if somebody wasn't showing up for appointments, I didn't see anything that looked at why would that be and how could we get around that.

Q Could you give an example of an individual you reviewed who received inadequate discharge planning services at a state hospital in Mississippi?

A Yes. Person 144.

Q Could you introduce person 144 briefly?

A Yeah. He's a Caucasian male in his mid 30s. When I

interviewed him, he was actually in the Calhoun County Jail. He has been sick since he was quite young, like late teens, also has a comorbid substance use problem.

He does have a work history. He described working at a furniture factory, a local one in the area where he lives, and really described with some pride the number of different kinds of saws he was able to work. I tried to list some, but some of them I had never heard of.

He also described really liking music, especially playing the guitar, although he doesn't have that anymore, and he really likes to draw.

Q Would you please turn to page 136 of your report. Is this where you described person 144?

A Yes, it is.

Q Where did you interview person 144?

A In the Calhoun County Jail.

Q Why was person 144 in jail at the time?

A The sheriff told me that he was there because he was waiting for a state hospital bed.

Q At the time of your interview with him, when was person 144's most recent state hospital discharge?

A In 2016, November of 2016, November 22nd.

Q Ms. Burson, please turn to the tab labeled PX-1107. Please turn to the second page. What is this document?

A This is the Mississippi State Hospital discharge summary

for person 144.
Q And is this the discharge summary in connection with person 144's most recent state hospital discharge?
A Yes, it is.
MR. HOLKINS: Your Honor, I move this into evidence as PX-1107.
THE COURT: Any objection from the State?
MR. SHELSON: No, Your Honor.
THE COURT: PX-1107 is received in evidence.
(Exhibit PX-1107 marked)
THE COURT: Did we do that for PX-1103?
THE CLERK: Yes.
THE COURT: We did? All right. Thank you. All right. You may proceed.
MR. HOLKINS: Thank you, Your Honor.
BY MR. HOLKINS:
Q Please turn to page 6 of this document, Ms. Burson. I want to direct your attention to the section in the middle of this page titled "After-care plans." Do you see that?
A Yes.
Q Could you please read aloud the entry for after-care plans?
A "Follow up with the mental health center. Follow up with the primary care provider. Keep follow-up appointments at Region 7 Mental Health Center in Eupora on 12/2/2016, at 10 a.m. Next Abilify maintenance shot due on 12/14/16.

Continue all PO medications every day. Abstain from drugs and alcohol. Attend 90 meetings in 90 days. The family nurse practitioner instructed the patient to follow up with the primary care provider in three months, unless sooner. PRN for medication conditions and/or any other concerns. May obtain Prilosec over the counter. Monitor blood pressure and pulse two to three times per week, and record for the next primary care provider appointment."

Q Thank you. Let's turn back now to page 137 of your report. I want to direct you to the fourth paragraph on that page. Was this the discharge plan you described as setting person 144 up for failure?

A That was my -- that is my opinion, yes.

Q Why did you find this discharge plan set person 144 up for failure?

A Well, the discharge plan relied solely on him for the follow-through to execute it, so it did not factor in his extensive history of nonadherence to medications. It also didn't include engaging his parents or the community mental health center or the state hospital in some sort of a collaborative discharge planning process to look at how they might get him to attend to his medications, to get to those appointments, to get to 90 meetings in 90 days.

There was no plan included around outreach if he didn't show up for appointments. There were no -- nothing -- no

service that would include any kind of home visits to help establish any kind of the routines he would need to be established, establishing to take care of his health.

Q I would now like to pull up an excerpt from the deposition designations for Sheila Newbaker, who I will represent to the court is the social services executive for East Mississippi State Hospital.

MR. HOLKINS: Your Honor, this designation appears on page 108 of Exhibit 2 to the party's proposed pretrial order.

THE COURT: Okay. All right.

BY MR. HOLKINS:

Q Ms. Burson, I want to direct your attention to page 51, line 23 of this deposition designation, to the question that starts, "Do you think that East Mississippi." Do you see where I am?

A Yes.

Q I'm going to read the questions in this designation aloud. Could you read Ms. Newbaker's answers aloud?

A Yes.

Q And we'll end at page 52, line 19. Is that okay?

A Yes.

Q "Question: Do you think that East Mississippi State Hospital has a responsibility to ensure that the transition from the hospital to the community is as smooth as possible?"

A "Answer: Sure."

Q "Question: What does East Mississippi State Hospital do to achieve that purpose?"
A "Well, you know, we certainly make the arrangements. We make sure that the client is agreeable to the arrangements, they are aware of the arrangements and that we don't set them up for failure, that we, you know, make it as doable for them as we can."
Q "Question: What do you mean by set them up for failure?"
A "You know, place them where they won't have availability of services. We want to make sure they're able to get their medication, that they've got the appointment. We put it in their hand, look at transportation needs, try to get help with them -- try to help them with as many arrangements as possible for when they leave."
Q Ms. Burson, do you agree that state hospitals have a responsibility to not set their clients up for failure in the community?
A Yes, I do.
Q Returning to person 144, did you find that he was at serious risk of hospitalization at the time of the interview?
A I did.
Q Why?
A He was in the -- he was very symptomatic. He was in the Calhoun County Jail, and I was told by the sheriff he was waiting for a bed to become available to be admitted to the

state hospital.

Q What community-based services did you recommend for person 144?

A I recommended PACT and permanent supportive housing.

Q Was there any evidence that person 144 had been receiving the intensive services he needed to mitigate his risk of hospitalization?

A No.

Q And how does that relate to the ineffective discharge planning person 144 received?

A Well, he was not -- PACT services were not considered. I don't think they were available in his area. I also didn't see evidence of, if they weren't available, trying to piece together and collaborate around what intensive -- what more intensive kind of service did they have the capacity to provide in order to be able to try and mitigate and break up the pattern.

Q Ms. Burson, after adults with serious mental illness are discharged from state hospitals, what strategies do community service providers use to keep them engaged in services?

A Well, one key thing that people do to keep people engaged in services is they really try to get to know that person and what's important to them and make the services that they're providing align with what is important to that person, so -- so that the services are seen as highly relevant to that person

being able to do what it is that they personally want to do or feel like they need to be able to do.

Q Is one term for that strategy assertive engagement?

A Yes.

Q Why does it matter whether adults with serious mental illness are assertively engaged in treatment?

A Well, it matters for two main reasons. One is, for people that don't identify as needing mental health treatment, engaging them around the things that are important to them is entree into treatment for many people. The other -- so, for example, if somebody identifies with wanting to work, engaging with them around supported employment gets somebody in the door.

The other reason it becomes really important is people give up on treatment when they don't see their lives getting better. So when you are supporting them and connecting it with what it is that's important to them, that they want for themselves in their lives, they feel some momentum, and then they engage and make better use of treatment. They start to apply what they're learning more in their everyday lives. So it -- it pushes treatment further along.

Q In general, were the individuals in your review assertively engaged in community-based treatment after their discharge from the state hospital?

A No.

Q Could you give an example of someone you reviewed for whom the lack of assertive engagement was a barrier to accessing appropriate community-based services?
A Person 136.
Q How would you describe person 136, briefly?
A So he's an African-American male in his mid 40s. He has six children ranging from ages six or seven to 21. He lives with his mother. He's estranged from his wife and separated. He hasn't been employed since at least 2015.
Q Could you turn to page 86 of your report, please. Is this where you discuss person 136?
A Yes, it is.
Q Why does person 136 need to be assertively engaged in treatment?
A He doesn't think he needs mental health treatment. What he identifies as needing is a job and a better place to live.
Q How would assertive engagement help him participate more fully in treatment?
A Well, he doesn't engage with treatment because he doesn't see a need for it. So if he -- for example, if you get to know him and in interacting with him pick up on his desire to have a job, and then you work with him on, well, what would help you get that job and, you know, we have supported employment, and is that something that would -- you know, that you would be interested in getting support with, sometimes people will --

and oftentimes you'll see people take up and say, yes, I'll do that service, as long as I don't -- I'm not required to do something else.

Q Ms. Burson, on page 87 of your report, in the third full paragraph, you note that person 136 was discharged from the state hospital with an after-care appointment at Weems Community Mental Health Center. Is that right?

A Yes.

Q Ms. Burson, please turn to the tab in your binder labeled PX-1106. What is this document?

A This is a -- from the Weems Community Mental Health Center, and it's his intake assessment at Weems.

Q Are you referring to person 136?

A I am.

Q What's the date of this assessment?

A The screening date of this is 11/16/2017.

MR. HOLKINS: Your Honor, I move this into evidence as PX-1106.

THE COURT: Any objection?

MR. SHELSON: No, sir.

THE COURT: PX-1106 is received in evidence.

(Exhibit PX-1106 marked)

BY MR. HOLKINS:

Q Ms. Burson, please turn to page 5 of this document. I want to direct you to the section titled "Intake summary and

recommendations." Do you see that?
A Yes.
Q Could you read aloud the entries in that section?
A "Intake summary and recommendations. Home: IRS stated he lives with his payments. IRS stated he hopes to own his own place when he can get on his feet financially. Individual receiving services. Health: IRS stated he attends scheduled doctor's appointments and takes his medicine daily as prescribed by doctor. IRS stated he complies with doctor. Community: IRS stated his father has an outreach store, and he helps out in the store when parents need him to help. Purpose: IRS stated he wants his own place."
Q Ms. Burson, please turn to the tab labeled PX-1105. What is this document?
A This is the discharge service change summary for him from Weems.
Q Are you referring to person 136?
A Yes, I am.
Q What is the date of this record?
A March 12th, 2018.
Q So that's less than four months after person 136's intake assessment at Weems CMHC. Correct?
A Yes.
MR. HOLKINS: Your Honor, I move this document into evidence as PX-1105.

THE COURT: Any objection?

MR. SHELSON: No, Your Honor.

THE COURT: PX-1105 is received in evidence.

(Exhibit PX-1105 marked)

BY MR. HOLKINS:

Q Ms. Burson, what is listed as the reason for discharge?

A "No contact within specified time frame."

Q What is listed under discharge status?

A "Therapist terminated treatment."

Q Finally, in the text box, what discharge instructions and additional information are provided?

A "IRS did not come back to complete treatment plan."

Q How did Region 10 -- excuse me. How did Weems Community Mental Health Center fall short of assertively engaging person 136 in treatment?

A Although they took information down about what was important to him, to get on his feet financially, a job and to get another place to live, they didn't offer any connection or engagement or service around that, or there's no evidence of that that would make him want to use Weems services, and he's a person that didn't see a need to receive mental health treatment if it wasn't going to help him with what he needed.

Q Did you find that person 136 was at serious risk of hospitalization when you interviewed him?

A Yes, I did.

Q Why?
A He was actually symptomatic at that time when I met him, and he also was not receiving -- he told me he wasn't taking his medications. He showed me, you know, the bottles of them. And he -- and he wasn't receiving any mental health services to mitigate that risk. He told me that he went to the first intake appointment, and they just wanted him to fill out paperwork, and he never came back.

MR. HOLKINS: Your Honor, may I confer with counsel for a moment?

THE COURT: Yes, you may.

BY MR. HOLKINS:

Q Ms. Burson, let's revisit person 132 one last time. Could you turn to page 81 of your report. This is where you discussed person 132. Correct?
A Yes.
Q Could you remind us, at the time of your review, how many times person 132 had been admitted to a state hospital in Mississippi?
A He was admitted it looks like twice at a state hospital.
Q Once at South Mississippi State Hospital and once at East Mississippi State Hospital. Is that correct?
A Correct.
Q When you interviewed him, how did person 132 describe the experience of being in a state hospital?

A He said it made him feel like he -- like he wasn't a person.

Q How has the experience of repeated state hospitalization affected person 132?

MR. SHELSON: Objection. Calls for speculation.

THE COURT: If she can tell from the record, you may testify if it's in the record.

BY MR. HOLKINS:

Q Ms. Burson, based on your review of person 132's records, and based on your interview with person 132, how has the experience of state hospitalization affected him?

A Well, he describes it as feeling less like a person. It's like going to jail over and over again, what he describes is not having -- he's not doing things that he was doing, even though he was sick. He doesn't have -- you know he -- he was trying to go to school. He went to school. He's no longer trying to pursue his education. He was working. He's no longer trying to work. He has a driver's license and was driving. He still has a driver's license, but he's no longer driving. And he talks about not feeling like he's able and capable to manage his health and his illness. So he gets hospitalized, but he's not leaving with a sense of self-agency that he can manage the world.

Q For someone like person 132, who is at risk of losing his self-agency, how do you go about restoring it?

A Well, my experience has been, and what I've seen is what it really -- what it really takes when someone is losing their sense of self-agency is you have to get in there and form a relationship with them and build some trust because it's hard to get them to take the risk again. People become afraid of failing. They start to feel like they're not capable. And so you do it with them.

So a service like supported employment, for example, you help the person figure out what kind of job is going to be a good fit. You help them prepare for the job. You help them do the interview. If they lose a job, you help them figure out what went wrong and what they can do different. The whole thing is a learning experience. You celebrate every success that they make, everything that they do, that they do better, is a learning experience. And so you have to engage them around the management of their life and the everyday things that they do, and that builds their confidence.

And the effect of that is that they start to have all self-confidence that they can begin to manage their illness, that they can -- that if -- that if they get more symptomatic or something happens, that they have a sense that it will be okay, they can do it. This is a rough patch. This is not all that I am, and this is not something that I can't overcome.

Q Was person 132 receiving supported employment at the time you met him?

A No, he was not receiving supported employment.
Q Had he ever received that service?
A No, he had never received that service.
Q How would you describe the experiences of meeting person 132?

MR. SHELSON: Your Honor, how the experience affected her personally is of no relevance to this lawsuit, no disrespect intended.

THE COURT: Objection sustained.

MR. HOLKINS: I have no further questions, Your Honor.

THE COURT: All right. We're in an hour where this is a good place to break until tomorrow. We'll see you tomorrow, Ms. Burson. Spend as much money as you can here in Jackson. She is staying in Jackson, right?

Did you want to cross-examine her this afternoon?

MR. SHELSON: Oh, no, sir. Mr. Anderson asked me to -- you mentioned yesterday we may be starting a little later tomorrow, and he asked me to ask you.

THE COURT: We will. We will be starting later tomorrow.

MR. SHELSON: Yes, sir.

THE COURT: You can sleep in a little bit. With respect to tomorrow, we'll start at 10 a.m. tomorrow morning. I have a matter that starts at 9. We should be through long before 10, but just be prepared to start up at 10.

But we realized we have another matter scheduled tomorrow afternoon. Do we know what witnesses will be called tomorrow?

MS. RUSH: Your Honor, we have, in addition to Ms. Burson, we have another fact witness tomorrow who we expect her direct to last about an hour and a half. I should also inform the court our next -- our witness after that is an expert who is having some travel difficulties and is stuck in the Atlanta airport, so he may be coming in late tonight. So we can either hold him over for Friday morning or take him at some point late in the afternoon, if that's possible.

THE COURT: I tell you what. Let's start at 9:45 tomorrow morning, and we'll end at 3:15. I have another matter that starts at 3:30, and rather than start that 3:30 matter and then try to come back -- I think I'll be through with the 3:30 matter at like -- well, let's just play it by ear. I have another hearing for 3:30, so I'm thinking if we do finish up with this witness and get to the fact witness, and we'll see how it goes in trying to get in your expert. We may just hold your expert until Friday.

MS. RUSH: That sounds good, Your Honor. Thank you.

THE COURT: And maybe we'll be able to leave early -- maybe you all will be able to leave early Thursday, tomorrow, maybe about 3:00 or any time before then. I do have another matter at 3:30 that I need to take care of. I don't think it

will take very long, but I don't want to chop up what you might be doing tomorrow.

MS. RUSH: Okay.

THE COURT: All right.

MS. RUSH: That sounds good. Thank you, Your Honor.

THE COURT: Okay. Does that sound all right to the State, Mr. Shelson?

MR. HOLKINS: Yes, Your Honor. Thank you.

THE COURT: All right. All right. We'll start up at 9:45 tomorrow and then proceed -- proceed with the understanding that I do have that -- a 3:30 hearing in another matter. All right. Ms. Rush?

MS. RUSH: Apologize, Your Honor, but because of your morning hearing, should we clear counsel table for other parties?

THE COURT: You don't have to. I mean, you know, you can -- anything that you wouldn't want them to see is fine, but you don't have to move the computers or move the name tags or any of that type of stuff.

MS. RUSH: Thank you, Your Honor.

THE COURT: All right. Is there anything we need to take care of besides getting Ms. Burson down off the stand? You can step down. Is there anything else we need to take care of?

MS. RUSH: Not from the United States, Your Honor.

Thank you.

THE COURT: Thank you also much, and I'll see you all tomorrow morning.

(Recess)

CERTIFICATE OF REPORTER

I, CHERIE GALLASPY BOND, Official Court Reporter, United States District Court, Southern District of Mississippi, do hereby certify that the above and foregoing pages contain a full, true and correct transcript of the proceedings had in the aforenamed case at the time and place indicated, which proceedings were recorded by me to the best of my skill and ability.

I certify that the transcript fees and format comply with those prescribed by the Court and Judicial Conference of the United States.

This the 12th day of June, 2019.

s/ *Cherie G. Bond*
Cherie G. Bond
Court Reporter